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ABSTRACT

This fifth chapter in "The Challenge of Counseling in Middle Schools" looks at the issue of sexual maturation in early adolescence via four articles. "The Counselor's Impact on Middle-Grade Students," by Hershel Thornburg, examines physical, intellectual, and social developmental tasks of early adolescence. "Contraceptive and Sexuality Knowledge Among Inner-City Middle School Students from Minority Groups," by Peggy Smith, Mariam Chacko, and Ana Bermudez, describes reported sexuality and contraceptive knowledge of inner-city middle school adolescents from minority groups who participated in a free physical examination program. Differences by sex, race, and ethnicity are mentioned; trends and potential implementation of the findings for the school counselor are highlighted. "The Pregnant Adolescent: Counseling Issues in School Settings," by Peggy Smith, looks at adolescent sexuality and cognitive development, considers pregnancy outcomes, and discusses the family's role in the counseling process. "Pregnancy Counseling for Teenagers," by John Eddy, Ernest McCray, David Stilson, and Nancy DeNardo, provides an approach to counseling the pregnant adolescent using a step-by-step method. It describes the use of a structured interview providing both the client and the school counselor with a positive experience. (NB)

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Chapter 5

The Challenge of Sexual Maturation in Early Adolescence

In writing for *The School Counselor's* special issue on middle school counseling in 1986, Professor Michael Dougherty asked how can we explain the boy "who enters sixth grade looking like a hobbit and leaves it looking like the 'Incredible Hulk'?" or the girl "who enters sixth grade with dreams of womanhood and leaves it as a woman" (p. 167). Physical maturation, and particularly sexual maturation, has significant effects on self-concept and social relationships during the middle school years. Most young adolescents dwell on how to make themselves more attractive and acceptable to their peers. The media finds simple-minded ways to exploit this preoccupation of young people.

One of the many difficult challenges for middle school counselors is to attend to the concerns of adolescents about physical maturation and sexuality. One frustrated counselor recently commented:

> Just when I think I've done all that I can do in preparing students to understand themselves and their changing bodies, a sixth grade girl comes to my office and implores me to help her get an abortion. I'm glad she trusts me enough to come for help, but I don't have any easy answers. All the kids want easy answers. I wish they could talk with their parents as they talk with me. Why are they so afraid of their parents?

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The literature on adolescent sexuality is abundant and covers topics such as friendship, sexual identity, and adolescent pregnancy. Chapter 5 presents information to help middle school counselors understand (a) the impact of physical and sexual maturation on students' lives and (b) the implications for middle school counseling programs. In particular, the chapter deals with the difficult issues of contraception and adolescent pregnancy. As Hershel Thornburg notes in the lead article for this chapter, "the behavior of many middle graders is attributable to their identification with stereotypical images or models." Unfortunately, many role models for these youngsters are musicians and sports figures whose physical attractiveness is appealing but whose sexual behavior is hardly exemplary.

Counselors can help young people to think critically about public heroes and to choose role models carefully. In so doing, counselors can help middle school students to understand and live realistically with the complex process of physical maturation and human sexuality.

The Counselor's Impact on Middle-Grade Students

Hershel D. Thornburg

There are many reasons why middle-grade students have emerged as a vital age group in schooling and personal development. The primary focus of this article is on the dominant characteristics of these students and the knowledge base that school counselors must have to deal effectively with them. The behavioral potential of middle graders is emphasized. Understanding of this potential must be reflected in school policies and programs. As middle graders become more complex, so must the skills of the adults who are responsible for educating them. Today's middle graders are total persons engaging in and responding to a total society. It is essential, therefore, that teachers, counselors, and other school personnel prepare themselves more effectively for interactions with these students.

These youngsters acquire considerable intellectual sophistication as they direct their energies toward peer approval, search for autonomy and identity, expend boundless energy, and explore new frontiers. They are both refreshing and fragile; unique, yet bemusing. Educators, however, often do not carefully consider why this is so. A key element in effective middle-grade education is meeting diverse student needs. It would be a mistake to underestimate the complexity of such a task and an equal mistake to perceive the task as impossible. Counselors and others who influence decisions regarding education must accept the challenge to develop effective school environments for today's middle graders.

Developmental Tasks of Middle-Grade Students

One way to understand 9- to 13-year olds is to consider the major skills they should acquire and the tasks they should accomplish within this age range. Such skills and tasks are usually described within three domains of development: physical, intellectual, and social. To apply these developments, it is useful to describe them as developmental tasks, an idea

advanced by Havighurst (1952) more than 30 years ago. Developmental tasks can be defined as the skills, knowledge, functions, or attitudes an individual normally acquires during a specific period or age range. My writings (1970a, 1970b, 1979, 1980) have focused specifically on the developmental tasks of middle-grade students. In this article I expand these tasks to 8:

Physical development
- Becoming aware of increased physical changes

Intellectual development
- Organizing knowledge and concepts into problem-solving strategies
- Making the transition from concrete to abstract symbols (new task)

Social development
- Learning new social and sex roles
- Identifying with stereotypical role models
- Developing friendships
- Gaining a sense of independence
- Developing a sense of responsibility

Becoming Aware of Increased Physical Changes

Primarily because of better nutrition, general health care, and prenatal care, the ages of physical change have moved into the preteen years. Characteristic external changes in girls are a gain in weight, an increase in height, breast development, and an increase in hip size and pigmentation of hair (Frisch & Revelle, 1970). Girls begin this growth spurt at around 10, culminating with menarche, usually by the age of 12. The current mean age of menarche is 12.8 years (Hammer & Owens, 1973). The onset of menarche is usually one year earlier in Black girls, although by the age of 15 virtually all girls have experienced it. Menarche should not be confused with the ability to reproduce. Research indicates that the anovulatory period (when eggs are not being released from the ovary) exists in most females for 12 to 18 months following menarche.

Male height, genital growth, and involuntary erections all begin around age 12. Evidence of enlargement of the testes and penis, pubic hair, and an increase in gondotropin by age 13 nearly complete the growth spurt, which begins tapering off by age 14 (Tanner, 1973). The

middle-grade boy is not as developed as his female counterpart, and his maturity is not comparable with hers until he is 16. Although it is not clear just how pubertal changes and psychosocial factors are related (Petersen & Taylor, 1980), Adams (1977) has observed that anxiety often accompanies physical growth, particularly when middle graders compare themselves with classmates or the prevailing stereotypes. It is important for these individuals to understand that variance in growth rate is normal and not symptomatic of problems.

Organizing Knowledge and Concepts into Problem-Solving Strategies

During their elementary school years children gradually learn the concept of absoluteness (conservation) and the ability to classify, order, and group objects (concept learning). Middle graders learn that symbols or strategies can be used in various situations and are not limited to a specific context. This ability to generalize is prerequisite to learning strategies for solving problems (Gagne, 1985; Thornburg, 1984). When middle-grade students learn a concept, they create a basis for learning new information and for retrieving relevant information that has been learned. Learning experiences in school can be structured so that there is an easier transition into more sophisticated uses of thought. By Grades 5 and 6, information is ordered, organized, and structured in the mind. By Grades 7 and 8, deductive reasoning and reflective thinking are operating, thus giving greater flexibility to thought.

Making the Transition from Concrete to Abstract Symbols

The process by which thoughts move from concrete to abstract symbols has not been well defined. The ability to make this transition probably begins when middle graders use concrete props for abstract thinking. With use, concrete reference points gradually disappear as an individual's abstract abilities become better defined. Middle-grade students gradually learn symbols (words) that contain abstract components (functions within the mind) rather than concrete ones. As middle graders increase their capacity for abstract thoughts, they tend to abandon the concrete, less flexible, thought patterns for abstract, more flexible reasoning (Thornburg, 1982). For example, concrete thinkers do not demonstrate the ability to see relationships between ideas, whereas

abstract thinkers generally do. Concrete thinkers typically function through the literal interpretation of content or classroom materials. By comparison, abstract thinkers are capable of going beyond literal meaning as they both interpret and apply presented information.

The transition from abstract thinking to concrete thinking is believed to occur between the ages of 10 and 12. It is important to understand that these transitional thinkers have predominantly concrete thoughts. During the middle grades they will not become abstract-dominant thinkers except in a few cases.

One major misunderstanding is the belief that middle-grade students should be more abstract, sophisticated thinkers than they are. Research confirms that middle-grade students with predominantly concrete thoughts are often labeled as having learning problems. This is unfortunate because the problem lies more in adults misunderstanding the capacities of middle graders than it does with the learning deficiencies of the students. The problem that students encounter is tied to the transitional nature of cognitive development. Students "turn off" or slow down because they have difficulty coping with the abstract thinking the curriculum demands, yet they come into the classroom primarily with a concrete rather than abstract language system and knowledge base. The problem is not that students are incapable of handling complex thinking processes and cannot be expected to master new subject matter. Instead, students are capable of coping with new, abstract, instructional materials if they are taught the necessary new language and thought processes (Thornburg, Adey, & Finnis, 1985).

Learning New Social and Sex Roles

Society sets patterns of accepted social behaviors. Many traditional roles have given way to more contemporary, alternative roles, particularly for women. As role models become more diverse, middle graders experience more conflict between the traditional roles they are carefully taught and the contemporary roles they observe. Potential conflict areas include greater assertiveness and individuality, greater educational and occupational opportunities, more individual choices and fewer group choices, more open social norms, and changes in family structures.

Archer (1982) and Waterman (1982) found that despite any role conflict or ambiguity, both sexes use the same means in seeking identity. This finding implies that today's middle graders are aware of a more open role system and exercise the opportunity to explore diverse roles

void of traditional stigma. Even so, Archer (1985) found that middle-grade girls received little teaching regarding either family roles or career roles. She suggested that the roles of middle-grade girls could be enhanced through more direct discussion of role opportunities and options.

It is clear that educational environments contribute to socialization. Although it is impossible to assess the strength of the impact of an educational environment, it is likely that school configurations specifically designed for 9- to 13-year olds, such as those in middle or junior high schools, will increase earlier socializations. This may be determined partly by the philosophy of the school. If it operates like a mini-high school, then earlier socialization is likely to occur. In contrast, if the school is geared to the physical, educational, and social needs of its students, then early socialization is less likely to be accentuated and contemporary social and sex roles are more likely to be discussed and realized.

Identifying with Stereotypical Role Models

The behavior of many middle graders is attributable to their identification with stereotypical images or models. Middle graders in transition are changing from children into adolescents. Thus, they tend to identify with images of more mature and independent behavior, particularly when displayed by very popular role models such as musicians, artistic performers, and sports figures.

Middle graders are also concerned about their appearances. Clothing and cosmetics merchandizers propagandize a mature, attractive look for children of this age. Research on physical attractiveness indicates that these individuals are very concerned about their appearance. Boys identify strongly with the masculine (mesomorphic) look, which emphasizes their height, shoulder width, and body proportions. Girls are concerned about the shape of their hips, legs, breasts, and waist (Adams, 1977).

The anxieties of these middle graders are accentuated by society's emphasis on early maturation and physical attractiveness (Shea, Crossman, & Adams, 1978). The closer a middle grader's body fits the social stereotype, the greater is his or her reinforcement and the less the anxiety. As adolescents begin to accept themselves for what they are, anxiety about personal appearance is reduced and elements of personal pride begin to appear. The prevalence of athletic events, musical events, beauty contests, award shows, and media productions stressing beauty,

manliness, "sexiness," and "withitness" all facilitate middle graders' identity with stereotypes.

Developing Friendships

The curious and exploratory nature of middle graders results in the development of friendships and the formation of peer groups. In Grades 5 and 6, associations are primarily with the same sex; by Grades 7 and 8, heterosexual associations are more common. Knowing one is acceptable to and can accept others is an important accomplishment in human development. At the same time, friendships produce a sense of belonging and a sense of independence from adult monitoring or restrictions. Peer associations are also instrumental in helping middle graders to develop interpersonal skills. Groups share ideas as well as behaviors, solve problems, have good times, and provide a sounding board for each other. Dougherty (1980) suggested that these processes are facilitated if middle graders are taught basic skills in communications and human relations.

Epstein (1983) has noted that persons who become close friends are those who are in close contact with each other. The way in which the school day and students are scheduled will greatly influence the nature of friendships. Epstein has also focused on the importance of status. Status may be defined in terms of what a middle grader has or does. Middle-grade students are most likely to reach out to those of equal or higher status. In such cases, status is defined by various conditions, such as popularity, athletic ability, age, sex, intelligence, or socioeconomic status. Studies on preteen behaviors, including drug use, sexual activities, delinquency, female pregnancy, and runaways, also provides insight into reciprocated friendship behavior.

Gaining a Sense of Independence

As middle graders increase their range of behaviors, they set in motion greater desires for and fulfillment of autonomy or independence. They begin to view themselves as individuals and develop their own role definition independent of adults. Achieving independence has always been difficult for American adolescents; yet, it is this distinction between not being an adult and being one that causes many to become interested in adultlike behaviors.

In the process of normal development, middle graders begin to exercise the right to make choices. As they make these choices, they often have conflicts with parents and other adults (Emde, 1979); Yarrow, 1979). Such conflicts may be generated by the youngster's need to relinquish childhood ties and find satisfying independent behaviors that are not overpowering. Physical maturation causes an individual to want less parental control. Improved social skills learned through peer interaction foster self-reliance and a degree of independence. Although such behavior may indicate independence, it should not be misconstrued by adults as independent behavior that does not need continued guidance and emotional support. Rather, parents and professionals must recognize the middle grader's growing concern with making choices. Suitable experiences that facilitate gradual independence must be provided (Thornburg, 1980, 1982).

Developing a Sense of Responsibility

During the middle grades the dominant influence on a child's behavior shifts from the parents to his or her peers. When this occurs, the likelihood increases that many parental, teacher, or societal standards will be challenged. Preteens will identify discrepancies between adult behavior and their own. They will ask why smoking, for example, is acceptable for an adult but not for them. They are less likely than previous generations to agree with the explanation that it is all right "because parents are older." They will question why teachers favor some students and pick on others. Their friends will be their greatest sympathizers in the process of trying to unscramble these discrepancies. These are some ways in which moral definitions or redefinitions occur.

Many middle schoolers have been reared in a society characterized by individuality. This often is converted into the belief that "no one has the right to tell me what to do." This conviction is often reinforced by older siblings, peers, parents, teachers, and the media, and it raises the question of whether or not an individual exercises personal rights within the context of personal responsibility. In a real sense, adults and society have done children and youth an injustice by failing to teach them the reciprocal relationship between rights and responsibilities. Such learning can occur if students are given increased opportunities to select their own activities and evaluate the outcomes of their behavior. Typically, in classrooms, students respond to activities set up by teachers and

evaluated by teachers. Yet, this type of responsibility is not the same as planning, carrying out, and evaluating one's own behavior. Middle graders need the opportunity to do both.

Implications for School Counselors

The basis of one of these eight developmental tasks is related to physical development, the basis of two of them is related to intellectual development, and the basis of five of them is related to social development. In general, schools tend to ignore physical and social development while stimulating intellectual development. In reality, schools should be better balanced, because the developmental needs of middle graders are much broader than academic pursuits. Counselors are more likely than are classroom teachers to interact with students in nonacademic areas. To be effective, counselors must demonstrate this broad knowledge base that middle graders have a need to fulfill during these important developmental years. Below are five capacities counselors should have, although these capacities are not exclusive.

Counselors must have a general information base with respect to the developmental characteristics of middle graders. It is important to understand the capacities of middle graders; the way they develop, learn and behave. It is equally important to understand both the positive and negative sources affecting their social behavior. In essence, counselors must have a general knowledge so they can relate to middle graders on initial contact and begin identifying ways to help them.

Counselors must understand the specific developmental tasks middle graders feel the need for or are expected to achieve. Although the developmental tasks discussed in this article have inherent logic, it is important to understand why each task is set in motion and what factors affecting an individual student either facilitate or inhibit task fulfillment. The behavior of virtually all middle graders can be classified in one of these eight task categories or as an interaction of two or more tasks. Counselors, therefore, must know the categories as well as common behaviors that fall within the categories.

Counselors must be knowledgeable about the specific individual with whom they are interacting. General and specific knowledge bases will prove ineffective in working with a student unless there is a sufficient knowledge base of the student himself or herself. In addition to the general ways these youngsters are described, there are unique or special

circumstances affecting most students who seek out a counselor. School performance, family situations, personal feelings and attitudes, and personal behavior are all factors counselors need to know about if they are to be effective with individual students.

Counselors must understand the perspective of the student. Counseling situations are not intended for the counselor to convince the middle grader or for power struggles in which the counselor wins. Students often seek out counselors because of conflicts they encounter with parents, teachers, or friends. Counselors must listen to determine how to best help an individual. The counselor's general and specific knowledge base provides a conceptual framework in which to interpret individual needs from that individual's perspective. Counselors are more likely to help middle graders understand their behavior, broaden their perspective, or accept themselves if they approach the problem from the students' perspective. As a basis of support for students, counselors should provide the direction needed to ease conflict resolution or encourage personal growth as well as to provide a sense of assurance and acceptance.

Counselors should teach skills that encourage decision making. Although the primary role of counselors is not that of teachers, they can be very effective in helping middle graders work through life situations. Counselors can help students bring personal problems into clearer focus and to explore options available to resolve conflict. Counselors can also help students to evaluate whether their solutions are reasonable and how they will convert various options into personal behavior. Counselors do help students understand choice; however, it is critical that they help students decide what choices mean in relation to self and others. Finally, middle graders, like adults, must have some inner feeling that the decision they have made is appropriate and thus self-fulfilling; that is, did the change in behavior solve the problem? Learning these skills will be useful to students well beyond the immediate situations in which such learning occurs.

Summary

In this article I have focused on the developmental and performance capacities of middle graders, approximately ages 9 through 13. Eight tasks were described as unique to this age range. These tasks should be either fulfilled or initiated in the course of normal development. The ability of middle-grade students to cope with these tasks and realize as

many as possible should increase their ability to function effectively during adolescence. Middle graders do need support from counselors and teachers because they may frequently be confronted with a task or behavior that they do not know how to resolve. In educational environments, therefore, it is important for adults to better understand the normal development and potential conflict areas of middle graders to effectively assist them in developing and understanding themselves as individuals—cognitively, affectively, and behaviorally.

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Contraceptive and Sexuality Knowledge Among Inner-City Middle School Students from Minority Groups

Peggy B. Smith
Mariam R. Chacko
Ana Bermudez

Historically, sex education, as an educational concern, can be traced back to the late 1880s. Recently, the sex education movement has been energized by the increasing amount of scientific literature reflecting the urgent need for education to prevent the morbid consequences of acquired immune deficiency syndrome (AIDS). Recent public opinion polls (Sex and Schools, 1986) have indicated that 86% of Americans favor sex education in the schools. This emphasizes that school counselors should focus on the issues of sexuality and contraceptive knowledge among the younger adolescents as they relate to birth control, health promotion, and disease prevention ("Sex and Schools,"). The need for this preventive information has been highlighted recently by the Surgeon General, who suggested that graphic instruction concerning heterosexual and homosexual relationships should commence at the lowest grade possible.

Although AIDS is currently rare in the adolescent population, problems related to adolescent sexual activity, such as sexually transmitted disease and parenthood, are not. Pregnancy rates among adolescents age 12 to 14 continue to be of concern and the prevalence of sexually transmitted diseases, especially chlamydia, is increasing (Mascola, Albritton, Cates, & Reynolds, 1983; Martien & Emans, 1987). The school counselor often must deal with the negative, cumulative effects of sexual behavior, underscoring the importance of the topic. Although initial investigations (Smith, Flaherty, & Webb, 1984; Smith, Nenney, & McGill, 1986) have defined the knowledge and attitude bases of middle and high schools, similar data on the knowledge base of younger adolescents is scarce. This article describes reported sexuality and contraceptive knowledge of inner-city middle school adolescents from minority groups

who participated in a free physical examination program. Differences by sex, race, and ethnicity are mentioned. Trends and potential implementation of the findings for the school counselor are highlighted.

Program Description

The free physical examination program provided by the Teen Health Clinic was extended to inner-city middle school campuses in a large public school district in the southwestern United States. The program had several objectives. First, free examinations would promote student participation in sports and extracurricular activities. Second, this was an opportunity to assess students' concepts of sexuality and contraceptive knowledge to determine the need to provide basic sex education. Finally, this was also an opportunity to establish a rapport with students who might need contraceptive services in the future.

During the school year the Teen Health Clinic staff selected five inner-city middle schools. This was based on a request for service by school personnel. School coaches and teachers recruited students and notified parents of their participation in the program. One school requested physicals but chose not to participate in the assessment of knowledge regarding sexuality and contraception. Thus, four schools participated in the assessment. None of the participating schools had a formalized sex education curriculum under way.

Instrument

The instrument used in this survey consisted of open-ended questions eliciting information about the level of sexuality and contraceptive knowledge, source, type and location of sexual knowledge. Examples of questions administered to middle school adolescents are as follows:

1. What does sex mean to you?
2. List five questions you have about sex.
3. Name as many ways as you know of to keep a girl from getting pregnant.
4. Who told you about the things you listed above?
5. How old were you when you learned these things?
6. Where were you when you learned these things?

The questionnaire was administered anonymously to the adolescents while they were waiting for their physical examinations; students were asked to record only ethnicity, sex, and age. The language used was English, written on a sixth-grade level for maximum student response. The credibility level associated with the knowledge source was also ascertained. Responses to questions 1 and 2 were reviewed by the three authors and assigned to one or more of the categories listed in Tables 1 and 2. Chi-square analyses were performed where indicated.

Results

Respondent Population

In four schools approximately 168 adolescents received questionnaires, and 116 students (70%) completed them. The ages of these respondents ranged from 12 to 15 years, the average age being 13. Of the 116 students, 24% were age 12, 44% were age 13, 29% were age 14, and 3% were age 15. Of this group, 60% were girls and 40% were boys. Twenty-seven percent were Hispanic and 73% were Afro-American. Caucasian students did not attend these schools and, therefore, were not involved in the program. Because completion of the questionnaire was voluntary, we did not obtain demographic information for all of the respondents.

Knowledge of Sexuality

Responses to the question "What does sex mean to you?" are listed in Table 1. Sixty-eight percent (79 of 116 students) responded to this question. It was interesting that almost one-third of the respondents stated they "didn't know" what sex meant to them or that sex "doesn't mean a thing." Of the adolescents who stated a recreational point of view ("fun"), 70% were boys.

Responses to "List five questions you have about sex" are shown in Table 2. Forty percent (47 of 116 students) listed one question. Respondents were primarily girls (79%). More than half asked questions related to moral issues. For example, "Is it right to have sex when you love somebody?" and "When are you old enough to be ready for sex?" Moral issues were followed in frequency by pregnancy, the sexual act, and feelings about sex and pregnancy. Examples of the latter were "How does it feel to be pregnant?" and "Will you regret it afterward?"

Table 1
Responses to "What Does Sex Mean to You"

	Total		Girls		Boys	
Category	*N*=79	%	*n*=49	%	*n*=30	%
"Don't know" or "Doesn't mean a thing"	25	32	18	37	7	23
Romantic	17	21	11	22	6	20
Feelings	12	15	9	18	3	10
Recreational	10	13	3	6	7	23
Anatomic	10	13	6	12	4	13
Unable to categorize	5	6	4	8	11	3

Contraceptive Knowledge by Sex and Race/Ethnicity

Of the 114 adolescents responding to this question and providing necessary demographic information, 81% could name one or more methods of contraception (see Table 3). Girls were more likely than boys to name at least one method, 89% versus 57% ($x^2 = 15.10$, $df = 1$, $p < .05$). Of those

Table 2
Responses to "List 5 Questions You Have About Sex"

	Total		Girls		Boys	
Category	*N*=47	%	*n*=37	%	*n*=10	%
Moral	28	60	21	57	7	70
Pregnancy	20	42	18	49	2	20
Sexual act	19	40	13	35	6	60
Feelings	16	34	13	35	3	30
Birth control	7	15	6	16	1	10
STD information	4	8	1	3	3	30
Growth and development	2	4	1	3	1	10
Homosexuality	2	4	2	5	0	0
Abortion	2	4	2	5	0	0
Talking to parents	2	4	2	5	0	0
Masturbation	1	2	1	3	0	0

Table 3
Number and Percentage of Students by Race Who Named Contraceptive Methods

Race	Methods Named				Total
	None		One or More		
Black	19	28%	49	72%	68
Hispanic	3	6%	43	93%	46
Total	**22**	**19%**	**92**	**81%**	**114**

Note. $x^2 = 10.03$, $df = 1$, $p < .05$.

naming at least one method, girls were more likely than boys to name two or more methods of birth control (69% versus 33%). Of the types of birth control named, condoms were named the most frequently (44%), followed by abstinence (36%), and the pill (8%). Nonprescription birth control methods were also listed by 32%. Other methods were named much less frequently. The method listed most frequently by girls was abstinence and, by boys, condoms.

Hispanics were more likely than were Afro-Americans to name at least one birth control method ($x^2 = 10.03$, $df = 1$, $p < .05$). Hispanic girls had the highest average number of methods named among those naming a method (2.2), followed by Afro-American girls (1.9), Hispanic boys (1.8), then Afro-American boys (1.3).

Knowledge of birth control methods was also measured by the number of questions pertaining to sex. Those who named no method of birth control were more likely to list no questions on sex (86%), compared to those who named at least one method (47%) ($x^2 = 9.703$, $p < .002$).

Sources of Sexual Information by Sex of Respondent

To the question "Who told you about sex?" 30 of the 46 boys and 55 of the 68 girls responded (114 total who indicated their sex). Among the girls, 53% (30 of 68) listed mother, 1% (1 of 68) listed father, and 6% (4 of 68) listed a friend. Among the boys, 17% (8 of 46) listed a friend, 17% (8 of 46) listed mother, and 11% (5 of 46) listed father. Books, school, television, or a doctor were listed as the other sources of information.

Discussion

Sexual concept questions were answered by 57% of the teenagers. Twenty-one percent of boys compared to 54% of girls listed questions about sex. This finding probably illustrates typical, concrete thinking patterns of this age group and is associated with the physiological and developmental differences by sex (Mussen, Conger, & Kagan, 1979).

Differences by sex were also observed in sources of sexual information. Girls proportionately received more information from their mother or both parents compared to boys. The peer group provided sexual information for 17% of the boys but did not function as the primary source. This trend suggests that, at least for the middle school girls in this study, parents are seen as credible and perhaps even approachable in matters of human sexuality. This finding supports school counselors in encouraging parents to continue to initiate dialogue with their adolescents about human sexuality. The sources of information listed by the boys can be interpreted in the following ways. If a general lack of interest is disregarded, the significant influence of the male peer group in setting the sexual frame of reference in early adolescence needs to be considered. Again, this data should encourage parents to discuss sexual matters earlier in their male child's psychosexual development than has perhaps been done previously (Dryfoos, 1985).

Although the questionnaire language was written on a sixth-grade reading level, refusal to complete the first two questions may reflect cognitive ability levels rather than typical adolescent rebellion and noncooperative behavior. Feelings associated with sex may be hard for middle school children to express conceptually, not because the content is proactive and embarrassing but because it is an abstraction that is difficult for this age group to comprehend. This cognitive deficit for this age group still poses a dilemma for the school counselor on how to present important, albeit abstract, information in a health-promoting and timely manner.

Both girls and boys responding to the questionnaire requested more information on the moral aspects of sexual activity and pregnancy. This emphasizes the need for the school counselor to incorporate values into sex education rather than focusing only on growth, development, and the anatomy of the reproductive system. The peak ages at which sexual concepts are learned are between 12 and 13 years of age (Thornburg, 1981), supporting the viewpoint that sex education should be introduced before junior high school.

The responses to questions about contraceptive knowledge from this younger adolescent group reflect several interesting trends. Not surprisingly, condoms were the most prevalent method named by the boys. Surveys of high-school-age adolescents reflect similar trends (Settlage, Baroff, & Cooper, 1973). The familiarity of adolescent boys with this method and its accessibility without requiring a prescription may contribute to this finding. Despite the fact that the condom was listed most frequently, the boys, especially Afro-Americans, seemed to be the least informed about other pregnancy prevention methods. Strategies for rectifying this situation are needed, because it is usually the boy who initiates the sexual encounters in adolescence and early adulthood (Miller, & Simon, 1980).

The responses on contraceptive knowledge by the Hispanics were somewhat surprising. Hispanics were more likely than Afro-Americans to name at least one method, and Hispanic girls had the highest average number of methods named. Considering that this group has high fertility during adolescence (Smith, & Wait, 1986), one may question the reason for lack of translation of knowledge into effective fertility control. Further investigations concerning motivation or cultural factors may provide insight into the reasons it is so difficult for teenagers to implement knowledge into effective practice.

Limited conclusions can be drawn from the investigation, because selection bias may have affected these results. Although parental consent was not reported as a potential deterrent by students or school personnel, the group participation may be affected by self-selecting factors based on the desire for a free school physical examination. In addition, because of the middle school student's limited educational and cognitive background, only the shortest and simplest questionnaire compatible with the desired information was used. Open-ended questions were also used to avoid prompting. In many instances, more lengthy and relevant questions would have produced much more meaningful information. Based on preliminary pilot testing with similar client groups, lengthy inquiries could not be used. Consideration of the length of questions thus limited the scope of the information gleaned and the depth of interpretations of the raw data gathered. In addition, comparisons of our ascertained knowledge base to a middle school with an established sex education program would provide further information.

Unfortunately, no such program in our general region was available for validation. However, information of the type gathered in our survey

is important to counselors in school settings because it provides information on sexual practices of the younger adolescent, who is at high risk for pregnancy. Information on beliefs and knowledge about sexuality among middle school students is rare. Such data reveal the formation of sexual attitudes among inner-city teenagers that have an impact on their future sexual relationships.

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The Pregnant Adolescent: Counseling Issues in School Settings

Peggy B. Smith

Prevalence statistics on the younger teen indicate that pregnancy in this age group is increasing. In 1961 there were 7,400 births to teenagers under 15 years, and in spite of the liberalized abortion laws the number of births in 1976 to girls under 15 rose to 12,000 (Baldwin, 1979). Because these adolescents are usually still in school when pregnancy occurs, the counselor in elementary and middle schools may be the first professional to provide guidance to the pregnant adolescent (Edwards, Steinman, Arnold, & Hakanson, 1980). The purpose of this paper is to selectively identify and discuss some of the key counseling issues surrounding adolescent pregnancy in the younger teen. They are not all-inclusive, but represent the kinds of problems the counselor must face in resolving the consequences of sexual activity and pregnancy in this younger age group.

Adolescent Sexuality and Cognitive Development

To effectively counsel the adolescent who suspects that she is pregnant, the counselor first needs a basic understanding of the evolving sexual orientation of this group. Contrary to the perceived sexual sophistication of teens, the younger adolescent may be struggling with her sexuality especially as it relates to cognitive and emotional developments. While this psychosexual development is a normal component of adolescent behavior, it exerts a powerful influence on the way younger teens cope with sexual feelings and experiences. For example, the transition from the concrete to the abstract, as described by Piaget, significantly affects the way the adolescent perceives the consequences of her sexual behavior. Associated with these formal operations is the ability to think hypothetically, anticipate future results, and forecast the logical consequences of one's behavior, all prerequisites to contraceptive use. Until such abstractions are mastered, which in some cases may not occur until

the adolescent is 13 years of age (Conger, 1973), the relationship of intercourse, ovulation, and pregnancy as well as the need for contraception may not be clear. Not always comprehending the synchronization of the reproductive system, the younger teen is unable to process, serialize, and synthesize contraceptive knowledge. Moreover, relying on concrete examples with concrete conclusions, the teenager's applications of preventive information are limited. Lipsitz (1980) suggests that most young adolescents are unable to think about contingencies, probabilities, or that "it can happen to me." Such cognitive unresponsiveness reflects emotional and intellectual immaturity. This immaturity, however, will not physiologically compensate by a reduction in the ability to conceive. This group of adolescents, once sexually active, is therefore at a serious risk for unintended pregnancy. The counselor thus must first ascertain if adolescents understand the basics of reproduction and if they can comprehend the relationship of intercourse to pregnancy before initiating the counseling process.

For teens whose pregnancies are not confirmed, the role of the counselor is still crucial. The pregnancy scare, while probably not deterring future coitus, will provide the counselor with an opportunity to initiate dialogue concerning contraceptive counseling and pregnancy prevention.

Pregnancy Outcomes

For those teens who are pregnant any counseling encounter will eventually focus on the reality of the conception and on options for dealing with the situation. One of the first steps in resolving a young teen's pregnancy crisis is to convince her that she is actually pregnant. Confusion about basic reproduction may often retard acceptance of this reality. Some teens go so far as to deny that intercourse ever occurred, or that since they don't look pregnant they are not pregnant. The counselor, if aware of the teen's presumptive signs of pregnancy such as amenorrhea, weight gain, or anorexia may have to explain the relationship of these signs to conception. Swift acknowledgment of the inevitable by the teen is crucial. The first trimester is the optimum time to consider all options and to rally the teen's support systems so that preventive contraceptive counseling or the consideration of the alternatives of abortion, adoption or parenthood can be introduced.

These alternatives, however, are fraught with unique dilemmas for both teen and counselor. Since 1973 abortion has legally been available

to the adolescent. Although one-third of all legal pregnancy terminations were performed on this age group, the decision to have a procedure by the teen is often difficult. The significant people in her life, which can include her parents and her sexual partner, may be actively attempting to influence her pregnancy-outcome decision. The counselor should be aware that their persuasiveness may be very subtle or very direct. The counselor may have to assume the role of a mediator or actually protect the adolescent from overly coercive parents. In addition to the external pressures, the abortion alternative is time limited. The decision to abort optimally should be made during the first trimester, a time when the younger teen is usually the most confused. The moral aspect of the decision is also important. The counselor should be aware that dialogue with the teen's spiritual leaders as well as her family may be appropriate.

Adoption, seen as a positive solution by some, has become the teen's least chosen alternative. Adolescents potentially interested in this option often succumb to attractions of the single parenthood model set by friends who indicate that they would rather abort than place a child for adoption. The fact that nine out of ten teens nationally will keep their babies and that adoption records are no longer permanently closed diminish this alternative's appeal. Counselors sensitive to the pregnant teen's vulnerability to such influence can perhaps enhance the integrity of the adoption option by initiating intense and continual support early in pregnancy. Aggressive counseling possibly can sustain the original adoption decision to the logical conclusion of termination of parental rights.

Possibly by default, parenthood is the most frequently chosen pregnancy resolution among adolescents. The emotional and educational costs are often great, with only a few adolescents surviving the pressures to enter the middle class mainstream. Key components in this struggle are the ways the family and the father of the baby become involved in the pregnancy process.

The Family in the Counseling Process

Acknowledgement of the family's role in the resolution of the problems associated with younger teen pregnancy is philosophically and pragmatically important. Philosophically, the family as the basic societal unit is given responsibility for the care and nurturance of any young, albeit

illegitimate, under its auspices. Its basic resources such as food, shelter, and clothing are usually extended to the single adolescent and her child. Operationally the family also provides a variety of important sexual guidelines that may subtly enhance the possibility that conception will occur. Included in these guidelines are factors such as formal and informal codes of conduct that legislate acceptable social-sexual behavior within the family. Such codes may specify, by design or default, conveyed sexual instructions, dating patterns, curfews, and even sexual practices. The counselor should be aware that some time during the pregnancy such sexual rules need to be reexamined and renegotiated. Otherwise, sexual situations that precipitated the first conception might be maintained, resulting in a second pregnancy. The degree of parental supervision also may enhance the possibility of an unintended pregnancy, especially in light of the fact that the home of the girl or boy is the most frequently cited setting for coitus after school.

As the family is a key factor in the younger teen's coping with pregnancy, the counselor may help to identify concrete ways the family can support the adolescent in this period of crisis. Prior to the actual birth, the family should be encouraged to enroll the adolescent in a prenatal clinic. Entrance into a health care system is accompanied by multiple clerical and administrative problems often exceeding the frustration threshold of the teen. In many cases parental participation is mandatory. Without proof of parental income and a payment deposit, clinic participation is limited. Again, counselors should attempt to involve parents early in the process so that such financial arrangements can be made and medical care provided in the first trimester.

Once the baby is born the family is a key factor in day-care provision. Many adolescents, without the family's help, are unable to secure adequate childcare facilities. Such support services are crucial in the early months of the infant's life; immediate day-care will in many cases allow adolescents to complete an academic year and minimize the risk of permanent school drop out. The counselor should be aware that such services from family members are not without trade-off. Some families, in an effort to help the teen, take all the parental prerogatives. Daily routine and health care needs are determined, in many cases, not by the child's biological mother but by the teen's parents. In extreme cases the child may be temporarily given to other family members in a functional foster care situation. Furstenberg (1978) suggests that such support systems may ultimately trap the young mother in her family unit, limiting her future marital prospects and her ultimate independence.

Involving the Father of the Baby

While the involvement of the family in the counseling process has included both the nuclear and extended definitions, some controversy exists as to whether the putative father should be automatically included in the family counseling. Such involvement appears to subtly influence the couple ultimately to marry. Klerman (1975) found that when teen fathers were substantively involved with the girl during the pregnancy, the pregnancy culminated with a marriage. Studies have also shown (Furstenberg, 1978) that, in general, the problem of adolescent pregnancy is compounded by the contracting of a marriage. The marital bond may subtly discourage academic and vocational effort. Responsibilities of home and husband may preclude educational continuance even when desired. Marriage may also provide an acceptable escape from the unpleasant school or family situation. Research (Smith, Mumford, Goldfarb, & Kaufman, 1975) indicates that the single girl's greater response to education in comparison to her married peer may reflect the lack of negative influences, or a greater motivation and awareness because of her singular need for more education or vocational training. The security of marriage does not seem to promote return to school and may even inspire a decision to stay home at least in the immediate follow-up period studied. In a family planning clinic sample, 70% (51) of the married teenage girls were out of school and remaining at home. The most plausible explanation for the difference is probably the number of living children. Of the married group, 85% (62) had at least one living offspring, while only 33% (138) of the singles had at least one child (Smith, Nenney, Mumford, Kaufman, & Leader, 1979).

The risk of repeat pregnancy is increased among married teens by their mediocre use of family planning services. Counselors should note that married teens, when compared to single teenagers, do not follow up as well on returns for contraceptive refills. In the same survey all patients accepting contraceptive methods are asked to return; yet of 293 scheduled returns, 96% (282) of the patients were single and only 4% (11) were married. The expected ratio of marrieds should have been approximately 15% (41). The lower rate of follow-up compliance for marrieds may be the result of several factors. Lack of child-care alternatives, lack of transportation, desire for additional children, or possibly a general lack of motivation may all minimize the possibility that the married teenager will return for a pill refill.

Recommendations

The convergence of cognitive, physical, and social growth, important developments for this age group, may enhance the girl's susceptibility for unprotected coitus. While counselors who work with adolescents cannot and probably should not try to alter the progression of these milestones, a variety of counseling strategies applicable to both the nonpregnant as well as the pregnant younger teen can possibly mitigate the risks associated with sexual development and maturation during early adolescence.

The first strategy is one of prophylactic education. School policy regarding the inclusion of materials on human sexuality as part of the curriculum should be reexamined. If teens are becoming pregnant in the middle school, then preventive information presented both in group and individual settings should be offered no later than the eighth grade. Education on sexuality "before the fact" can possibly deter initiation of coitus or, if intercourse does occur, encourage use of effective contraception. Such a suggestion is not without problems. Differential cognitive, cultural, and sexual patterns associated with various groups should be considered in curriculum content and emphasis. The politics of sex education in the school is also well known. Infusion or inclusion of such curricula, especially for the very young student, can be controversial. The counseling staff, however, may be able to provide valuable advocacy for provision of such information. Of school personnel, the counselor may be most aware of the sexual conflicts associated with this age group.

A second strategy should focus on selective involvement of the girl's sexual partner. One may want to stress male reproductive health education before conception instead of after. Family planning clinics should foster creative programs to reach this clientele. When pregnancy occurs the teen father should be involved in a counseling process, but his emotional needs possibly should be met in a setting or session independent of the pregnant adolescent and her parents. In the past when the teen boy and girl were perceived as a couple, marriage was expected. Such a psychological pressure when resulting in marriage terminates all the support benefits that may flow from the girl's family membership (Furstenberg, 1978). Subsequent separation or divorce of the girl from the father of the baby usually will not reestablish or reconnect familial ties with her family or origin.

A third strategy should involve the community and develop awareness of the magnitude of the problem. Individual community members or institutional representatives can help develop pregnancy prevention strategies. Community and professional leaders should be carefully educated to avoid using vague but emotionally appealing program descriptions popularized by some in hopes of obtaining support. One should not suggest that such innovations will completely eliminate teen sexuality, venereal disease, and pregnancy. Incorrect emphasis may distort the plight of the younger teenager when remedial or preventive options are considered by community groups. This is especially true when preventive alternatives are considered. Nonpregnant teens, not to mention the male sexual partners, may not receive accurate information or services that could prevent unintended pregnancy.

Once aware of the problem the community can identify alternatives compatible with local mores and standards. These can run the gamut of alternatives, from parenting classes to comprehensive family-planning services. When generated from local concerned citizens, these measures will pay dividends. Since their impetus is community leadership, they enhance acceptability, and maximize the possibility of continuation. Local involvement may also provide trained professionals who spontaneously involve themselves in the community effort at little or no cost. Conversely, if activities are orchestrated in a professional way, previously pregnant teens may voluntarily come forward and serve as peer counselors to warn their nonpregnant contemporaries of the consequences of unintended pregnancy.

Unfortunately a group of these younger teens, as the statistics reflect, will conceive; pregnancy prevention strategies become no longer appropriate and another strategy of maximizing prenatal outcome becomes the approach. Regardless of whether medical risks are associated with age instead of timely prenatal care, early entrance and continued maintenance in a health care system could address both factors. Several components exist in the maximization strategy. The first step in such a program would be to reach adolescents in the first trimester who are possibly pregnant. Information on presumptive behavior, in addition to physical signs, could provide counselors a potent diagnostic tool to work with teens. Such a tool would allow more options for young teens; however, operationalizing such a suggestion may require a redefinition to carefully balance the health benefits against the possible intrusion in the minor's right of privacy.

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Pregnancy Counseling for Teenagers

John Eddy
Ernest H. McCray
David Stilson
Nancy DeNardo

Foster and Miller (1980) stated, "few authors have discussed the role of counselor support during adolescent pregnancy..." (p. 236). Fyfe (1980) wrote, "Counselors in both school and agency settings are repeatedly involved in counseling situations that include sex-related problems" (p. 147). This article provides an approach to counseling the pregnant adolescent using a step-by-step method. This system uses a structured interview providing both the client and the school counselor with a positive experience.

The Problem

According to the 1979 report of the Office of Adolescent Pregnancy in Washington, D.C., over one million girls become pregnant annually. Of this number, approximately 600,000 have their babies, 300,000 choose abortions, and 100,000 have miscarriages or give up their infants for adoption (Poveromo, 1981).

Increases in sexual activity among teenage girls in America and exaggerated fears over usage of birth control pills have given rise to teenage pregnancies (Long, 1980). Moreover, results of a survey of 1,717 girls, 15–19 years old, showed an increase in sexual activity from 30% in 1971 to 49.9% in 1979. Actual pregnancies from that same group increased from 28.1% in 1971 to 32.5% in 1979. In addition, 55.5% of the 17-year-old males, 66% of the 18-year-old males, and 77.5% of the 19-year-old males had engaged in sexual intercourse (Kantner & Zelnick, 1979).

As Quinby (1980) pointed out, 80% of all first teenage pregnancies are conceived out of wedlock. Even a larger increase in teenage pregnancies would occur if family planning programs were not available.

Another factor influencing the sexual activity of youth is the change in family structure in America (Lifton, Tavantzis, & Mooney, 1979).

> Projections suggest that soon 45% of all children in the United States will be in single-parent families. The rapid geographic mobility of our society removes people from familiar settings and community supports. Today children and adults struggle as they seek support and help in facing life crisis. (p. 161)

Although uncommon in the past, broken households are estimated to be one out of seven children raised by a single parent and in cities up to one in four (Toffler & Toffler, 1981).

Surveys indicate that religious groups (Hopkins, 1980) and parents (Foster & Miller, 1980) are not providing youth with adequate information on teenage pregnancy. Attitudes may be changing, however, among many ministers. "Today an effective and competent minister must be at least conversant in psychotherapy, theological study, and counseling" (Faulkner, 1982, p. 22).

In addition to the lack of information provided to the teenager, "family life education, sex education, and contraceptive techniques are not permitted to be taught in some schools" (Foster & Miller, 1980, p. 236). The school counselor needs a systematic approach to deal with youths who are facing the difficulties of pregnancy. There are many variables involved in counseling any client, but the following suggestions might be helpful.

Pregnancy Counseling for the Individual

Level 1: Introduction and Rapport Development

The objective in level 1 is that the counselor, through provision of a caring atmosphere for the client's present needs, will enable the client to more easily express her problem.

> CLIENT: Mrs. Brown, I've got to talk to you.
>
> COUNSELOR: Okay, Jackie, I appreciate your taking time to come in. I sense a definite urgency in your voice.

The counselor should speak slowly if he or she notices that the client is particularly nervous and upset. Speaking slowly tends to slow down

thought processes so that the client can think more clearly. The counselor should also be aware of his or her own body language, eye contact, etc., and give full attention to the client, including her physical comfort. By attending to such details, a counselor is building a relationship and establishing a level of comfort from the start.

Level 2: Legality and Confidentiality

Level 2's objective is that the counselor, through inspection of existing laws and policies, will provide the client with guidelines as to the possible limitations of confidentiality in this case.

> CLIENT: I've got something very scary I need to tell someone, but I don't want my parents to know.
>
> COUNSELOR THINKS: (This could be a serious problem dealing with pregnancy or suicide. What are my legal rights and responsibilities in dealing with this case: Whom do I have to report?)
>
> COUNSELOR RESPONDS: Jackie, I see something is really bothering you, and I appreciate the trust and honesty you have shown in coming to me with your problem. Now, I want to be completely honest with you, I want to help you, but if this involves others...? (Time is needed here to think about it.) Do I have your permission to see your parents, if absolutely necessary?

Level 3: Affective Empathy

The objective in level 3 is that the counselor, through reflection of the client's affect, will provide the client with an empathic support system.

> CLIENT: Well, uh (sobbing now), I don't know who to turn to. (silence) I'm so nervous and afraid.
>
> COUNSELOR THINKS: (This could be a good time to respond to her affect and supply empathic support.)
>
> COUNSELOR RESPONDS: I want to be your friend and try to help. Let's work together on this. Okay?

Level 4: Directive Versus Nondirective Approach

Level 4's objective is that the counselor will decide how directive or nondirective to become with this client, by observing the client's body language, voice level, and other factors.

> CLIENT: Well, I'm pregnant! I feel so confused! My parents will just die! Please, tell me what to do!
>
> COUNSELOR THINKS: (This could require more affective responses that will influence my decision as to how directive or nondirective to be. Also, will my personal values become a problem in providing the student with all possible options? If I cannot consider abortion as an option, for example, perhaps the client needs to be referred to someone else.)
>
> COUNSELOR RESPONDS: You feel confused over what has happened, Jackie, and you'd like some advice. I understand what you must be going through now, and we can explore some alternatives together. (At this point, it could be important to determine how she has verified the pregnancy. Many young girls panic at a missed period and assume pregnancy.)

Level 5: Background Information

The objective in level 5 is that the counselor, through personalizing the choices with the client, will enable the client to deal with the problem from her present level of possibility. At this point, the counselor could ask the client how she sees the problem and what alternatives seem realistic to her. Or the counselor can begin gathering background data that will be important later.

Level 6: Alternatives

Level 6's objective is that the counselor, through provision of a wide variety of alternatives, will thoroughly explore with the client as many solutions as possible. The counselor would then obtain or suggest certain relevant factors, such as those listed in Table 1.

Table 1
Relevant Factors and Key Thoughts

Factors	Key Thoughts
A. Personal Choice	1. Does she *want* the baby? 2. Does her partner want the child?
B. Religious Influence	1. What is the significance of what she has done versus the church's doctrine? 2. Does her church allow abortion? 3. If the client has no religious affiliation, does she want referral to a clergyperson to discuss her alternatives?
C. Present Family	1. Can she stay at home during pregnancy? 2. Does she have other relatives to whom she can turn? 3. Would she rather live elsewhere during this time? 4. Would the partner or partner's family be of assistance?
D. Future Family	1. Is marriage a possibility? 2. Where would they live?
E. Financial Possibility	1. Do they have the money to have the baby? 2. Could they support the baby?
F. Referral Sources	1. Could such agencies as Planned Parenthood or a home for unwed mothers be of assistance? 2. Is adoption possible? 3. Is other individual counseling necessary? If so, where?
G. Career Options	1. What about short-range goals, such as completion of the school year and obtaining a diploma? 2. What future limitations are placed on long-range goals—i.e., possible loss of future educational or career alternatives?
H. Informational Services	
1. Medical Services	1. What hospitals, clinics, and specialized physicians are available in the area?
2. Parenting Skills	2. What childbirth, civic, and single-parent instructional groups are locally available? Could role-playing parenting skills be helpful?
3. Child Care Services	3. Is a directory of child care services available in the community?
I. Follow-up	1. The counselor and client together can look into these and other resources for help. 2. Further counseling sessions may be scheduled to encourage and guide the client.

A Model for Counselors

The school counselor is often in a strategic position to offer adolescents guidance and counseling in coping with pregnancy. Providing teenagers with competent, concise, and candid information is a valuable service by the school counselor for both adolescents and their parents or guardians. In this article, ideas were outlined to help the school counselor deal with the pregnant adolescent client. Therefore, the school counselor who uses this model has a step-by-step procedure that school counselors have been asking for in their counseling educational training (Eddy, 1981).

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